

LEGIONELLOSIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 49817 (R2/5-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this: ●
Not like this: ✗ ✓
Mark mistakes like this: ✗
- 4 Print capital letters only and numbers completely inside boxes.

A 2 C 3

Please complete all items on form.

Date format:
MM/DD/YY

Section 1. Demographic Information

Last Name

First Name MI Phone Number

Number & Street Address

City State ZIP Code

County Date of Birth Age

Race: ☐ Asian ☐ White ☐ Black or African American ☐ Other/Multiracial ☐ American Indian or Alaska Native ☐ Unknown ☐ Native Hawaiian or Other Pacific Islander
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Sex: ☐ Male ☐ Female ☐ Unknown
Is Age in day/mo/yr? ☐ Days ☐ Months ☐ Years

Occupation Phone of Employer/School/Day Care

Name of ☐ Employer ☐ School ☐ Day Care

Address of Employer/School/Day Care

City State ZIP Code

Section 2. Clinical Information

Symptoms:

☐ Fever _____ (degrees) _____ / _____ / _____

☐ Myalgia Date of Onset

☐ Cough
☐ Pneumonia (X-ray Diagnosed) Duration of Symptoms in Days

☐ Headache
☐ Loss of Appetite Date First Positive Specimen Collected

☐ Diarrhea
☐ Cramps
☐ Other, specify: _____

Method of Testing Used:

☐ Culture
Site: _____

☐ DFA Stain
Site: _____

☐ Serology (must have both titers)

Acute

Convalescent

☐ Urine Antigen
☐ Other, specify: _____

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City State ZIP Code

Physician/Hospital Phone

Was the patient hospitalized?

☐ Yes ☐ No

If Yes, admission date: ____/____/____

Discharge date: ____/____/____

Hospital: _____

Was the patient treated with antibiotics?

☐ Yes ☐ No ☐ Unknown

If Yes, antibiotic

Date started

Was the patient immunocompromised?

☐ Yes ☐ No ☐ Unknown

If Yes, why

Was infection associated with an outbreak?

☐ Yes ☐ No ☐ Unknown

If Yes: ☐ Convention ☐ Hospital ☐ Work ☐ Other:

If Other, specify

Outcome?

☐ Case survived ☐ Death due to Legionellosis ☐ Death unrelated ☐ Unknown

Section 3. Risk Factors

During the two weeks prior to onset of symptoms, did the patient:

Visit a hospital as an outpatient/inpatient?

☐ Yes ☐ No ☐ Unknown

If Yes, date: ____/____/____

Hospital name: _____

Work in a hospital?

☐ Yes ☐ No ☐ Unknown

If Yes, date: ____/____/____

Hospital name: _____

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Section 3. Risk Factors (continued)

During the two weeks prior to onset of symptoms, did the patient:

Travel outside of Indiana?

☐ Yes ☐ No ☐ Unknown

If Yes, where

_____/_____/_____
Date of departure Date of return

Stay in a hotel/motel overnight?

☐ Yes ☐ No ☐ Unknown

If Yes, place

_____/_____/_____
Date

Smoke?

☐ Yes ☐ No If Yes, how long (years): _____ Packs/Items per day: _____

Use a whirlpool/spa at home, in a health club, or elsewhere?

☐ Yes ☐ No ☐ Unknown

If Yes, where

_____/_____/_____
Date

Have exposure to any industrial cooling towers, showers, or air conditioners?

☐ Yes ☐ No ☐ Unknown

If Yes, where

_____/_____/_____
Date:

Do any gardening or work with potting soil?

☐ Yes ☐ No ☐ Unknown

If Yes, where

_____/_____/_____
Date

Use or have contact with a humidifier?

☐ Yes ☐ No ☐ Unknown

If Yes, where

_____/_____/_____
Date

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Section 3. Risk Factors (continued)

During the two weeks prior to onset of symptoms, did the patient:

Have contact with a decorative fountain?

☐ Yes ☐ No ☐ Unknown

If Yes, where

____ / ____ / ____

Date

Attend a convention?

☐ Yes ☐ No ☐ Unknown

If Yes, where

____ / ____ / ____

Date

Have an excavation or construction site within eyesight of home?

☐ Yes ☐ No ☐ Unknown

If Yes, where

____ / ____ / ____

Date

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

____ - ____ - ____ ____ / ____ / ____

Phone Number

Date